Task # III-1: Alert and Mobilize Emergency Operations Center Staff	
Outcome: Emergency Management	**Location:** EOC
Response Element: EOC Staff	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Incident notification and determination that partial or full Emergency Operations Center (EOC) staffing is necessary. **Conditions:** Availability of communications systems, availability of EOC staff, disease epidemiology, knowledge of plans and procedures, and current EOC staff rosters. **Expected Outcomes:** The EOC is staffed with personnel to manage the jurisdiction's response. **Typical Steps:** 1. Based on information from the incident scene, the Emergency Medical Director (EMD) or designee determines whether partial or full EOC staffing is necessary. 2. Determine whether incident restricts EOC staff routes to the EOC. 3. Recall required EOC staff using appropriate procedures, and advise of route restrictions, if any. 4. EOC staff safely proceed to the EOC. 5. Assess alternate EOC requirements. **Consequences:** Direction and control of critical public protection operations are provided for the duration of the jurisdiction's response. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*

- ✓ What happened?
- ✓ What was supposed to happen?
- ✓ If there is a difference, why?
- ✓ What is the impact of that difference?
- ✓ What should be learned from this?
- ✓ What corrective actions are recommended?

Initial Notification

1. Was the emergency management director or designated alternate notified of the incident? How was this notification made?
2. Did dispatch/communications initiate alert/recall procedures for EOC personnel? Was the recall list current?
3. Was the EOC accessible to the agencies or participants represented? Where was it located?
4. Was an alternative EOC location available? Was it used?
5. Was the EOC established in a safe and secure area? What security measures were used?

EOC Activation and Staffing

6. Did the appropriate authority authorize activation of the EOC?
   a. Who authorized the activation (name and title)?
   b. Were there plans and procedures in place for the activation process?
   c. Were these plans followed? Were they effective?
7. Did appropriate staff respond to the recall?
8. What capability exists to provide backup personnel for the EOC during a critical incident or outbreak?
9. What procedures were in place to address personnel rotation?

Task # III-2: Activate, Expand, and Operate Emergency Operations Center	
Outcome: Emergency Management	**Location:** EOC
Response Element: EOC Staff	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Decision to activate the Emergency Operations Center (EOC) and EOC staff mobilization. **Conditions:** Current facility operating status, time available for EOC staff to respond to the EOC, needed equipment and facility availability, communications systems availability, EOC staff availability, and knowledge of plans and procedures. **Expected Outcomes:** The EOC achieves its full operational status quickly and maintains this level of effort for the duration of the response. **Typical Steps:** 1. Upgrade facility from current to emergency status. Declare EOC operational. 2. Follow procedures for removing equipment from storage locations, ensure equipment is operating properly, prepare facility for emergency use, and review plans and procedures appropriate for the incident. 3. Concurrently with EOC activation or expansion, confirm that EOC communications systems (primary, backup, and alternate) are operational. Maintain an uninterrupted capability for the duration of the response. Immediately correct communications system malfunctions. 4. Brief EOC staff on the status of the incident and current response activities upon their arrival and at regular intervals thereafter. 5. Provide command, control, coordination, and leadership of emergency response activities. 6. Establish and maintain security throughout the response. 7. Promptly post information about the situation and decisions in the EOC. This information is archived for subsequent analysis, investigation, and preparation of official reports. 8. Plan for uninterrupted 24-hour operation, including publication of schedules that cover all shifts with adequate staff. 9. Maintain continuous EOC operations during rest, meal breaks, and shift changes. Conduct shift transition briefings in accordance with plans and procedures. **Consequences:** Direction and control of critical response operations is performed without interruptions caused by lapses in EOC staffing, communications systems malfunctions, or shortfalls in facility capabilities. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*

- ✓ What happened?
- ✓ What was supposed to happen?
- ✓ If there is a difference, why?
- ✓ What is the impact of that difference?
- ✓ What should be learned from this?
- ✓ What corrective actions are recommended?

Activation and Notification

1. Were current listings of key personnel and their telephone numbers for EOC activation available and used? What procedures were established to ensure the list(s) were current? Were these effective?
2. Were the participants you observed stopped and identified prior to entering the EOC? How was this conducted?
3. Were arriving staff appropriately briefed upon their arrival?
4. Were all agencies advised of the EOC's location? What agencies were notified?
5. Were copies of plans and procedures made available for all EOC personnel?
6. Was the plan implemented appropriately?
   a. Was the EOC organized by functions according to the Emergency Operations Plan (EOP)?
   b. What were the functional areas activated in the EOC?
   c. When was this plan last updated? Were plans and procedures effective?
7. Was the activation and response coordinated and efficient?
8. Was the EOC adequately equipped?

Roles and Responsibilities

9. Who assumed overall control of EOC operations (e.g., Emergency Medical Director [EMD], alternate)?
10. Describe the overall level of control maintained in the EOC. Did the EMD maintain appropriate control?
11. Describe the use of available resources and staff positions:
    a. Were they appropriately used to maximize efficiency and effective response operations?
    b. Were staff sufficiently trained to accomplish their duties?
    c. Did the EMD understand all functions to be carried out by different staff?
12. What liaisons from participating agencies/departments were present at the EOC?
13. Did the liaisons have decisionmaking authority for their respective agencies? If not, who had this authority?
14. Were the agencies/departments you observed properly equipped to perform their functions?
15. Was a determination of incident stabilization and termination of command made? How and by whom?

Coordination and Communication

16. Was a local emergency declared in accordance with plans and procedures? Who declared the local emergency?
17. Does the EMD have authority to use necessary resources to mitigate the emergency and coordinate additional elements?
18. What procedures were established to maintain a communications link or liaison with the incident scene/field operations, public health, and the EOC?

Task # III-3: Direct and Control Response Operations	
Outcome: Emergency Management	**Location:** EOC
Response Element: EOC Staff	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Reports from field operations, Incident Command System (ICS), and epidemiological investigation. **Conditions:** Availability of time; availability of trained emergency responders, health, and medical personnel; emergency plans and procedures; and conditions at variance with plans and procedures. **Expected Outcomes:** Direction and control of response activities is established, and activities of responders are properly directed and coordinated to ensure maximum efficiency of response operations. **Typical Steps:** 1. Assist the Incident Commander (IC) and staff with developing and implementing action plans and alternate plans to confine, collect, and contain the release. 2. If appropriate, assist health and medical staff with developing and implementing action plans and alternate plans to collect epidemiological data and contain the spread of the disease or health impacts. 3. Monitor communication between responders and ICS. 4. Receive status reports and make recommendations to the IC and staff regarding adjustments to operations based on the situation presented. 5. Direct the dispatch of available additional responders if on-scene needs are beyond the capabilities of first responders. 6. Direct the dispatch of specialized responders (as needed to support operations for a chemical, biological, or radiological incident). 7. Assist the IC and staff with developing and implementing mitigation plans. For biological incidents, assist local governments in developing and implementing mitigation/disease control plans. **Consequences:** Response operations occur quickly and successfully, eliminating further risk to the environment, workers, and general population. Resources are provided to areas of State where needed, mitigating further risk to the environment, workers, and general population. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*

- ✓ What happened?
- ✓ What was supposed to happen?
- ✓ If there is a difference, why?
- ✓ What is the impact of that difference?
- ✓ What should be learned from this?
- ✓ What corrective actions are recommended?

Operations

1. Were Emergency Operations Center (EOC) operations consistent with plans, procedures, and protocols? Were plans sufficient?
2. Did the EOC, in consultation with the IC, analyze information/data to formulate mitigation and corrective actions? Who else was involved in developing such actions (e.g., public health)?
3. Did EOC personnel maintain an account of incident events? How was this done?
4. Did the agency liaisons at the EOC have decisionmaking authority for their respective agencies? If not, who had this authority?
5. Did members of the agencies/departments that you evaluated maintain personnel accountability throughout the incident? How was this maintained?
6. Did the EOC respond to the need for additional responders at the site or other specialized support teams?
   a. What type of responders?
   b. What information was used to make this determination?
   c. How effectively was this implemented?
7. Does the emergency management director have authority to use necessary resources to mitigate the emergency and coordinate additional elements?

Information

8. Were progress reports given to all agencies where necessary? How often and by whom? What type of information was reported (e.g., search and rescue operations, site mitigation operations, disease mitigation operations)
9. Based on your observations, would you say communication with other agencies was adequate? On site, face to face? On site, radio? On site, agency to agency?
10. Was a media conference area established? Was the need for regular briefings and information releases recognized and acted upon? Who provided the briefings?
11. How were communications maintained between the various response elements (e.g., EOC, public health)? How did the EOC/Emergency Coordination Center (ECC) respond to communications overload?
12. How were communication requests for resources coordinated between agency dispatchers?

Coordination

13. Was the response to the incident unified and integrated? Did the agencies involved in this exercise demonstrate good teamwork and coordination?
14. Were there written agreements in place between appropriate agencies?
15. Were functional areas of responsibility assigned for direction/control and coordination?
16. How was the multijurisdiction/regional incident coordinated?
17. Did jurisdiction make use of mutual aid agreements with other local entities?
18. Was information/data coordinated and communicated among response elements?

Task # III-4: Notify Government Agencies and Officials	
Outcome: Emergency Management	**Location:** EOC/ECC
Response Element: EOC Staff/Public Health	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Reports describing the incident, and initial and updated health/hazard analyses. **Conditions:** Availability of time; availability of communications systems; knowledge of plans, procedures, laws, and regulations; and memorandums of agreement (MOAs)/memorandums of understanding (MOUs). **Expected Outcomes:** All appropriate Federal, State (including surrounding States), and local emergency management and/or public health/medical officials and agencies are informed about the incident and significant changes to the situation before the media and the public are informed. **Typical Steps:** 1. Make initial and followup notifications to local, State (including surrounding States), and Federal emergency response, medical, and law enforcement agencies. 2. Schedule advance party meeting with external agencies. 3. Notify local and Federal government officials of significant changes to the situation prior to press releases concerning the incident. 4. Maintain information flow with Federal, State, local, and tribal officials. **Consequences:** Local, State, and Federal government emergency management, health and medical, and law enforcement officials have correct information. The credibility of the EOC and public health officials as being responsible for statewide emergency response coordination and public health and safety is not compromised. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*

- ✓ What happened?
- ✓ What was supposed to happen?
- ✓ If there is a difference, why?
- ✓ What is the impact of that difference?
- ✓ What should be learned from this?
- ✓ What corrective actions are recommended?

Notification

1. What led to the decision to notify county, State, and higher offices?
2. Were there plans and procedures for this process? Were they followed? Were they effective?
3. Was an advance party meeting held with appropriate officials?

Coordination

4. Was there a coordinated response in sharing of information with local, State, and Federal agencies and officials?
5. Was there an advisory team for environment, food, and health?
6. Were the roles and functions of each level of government recognized, understood, and adequately performed?
7. Were all potentially impacted jurisdictions considered and included in coordination?
8. Were adjoining States and counties advised of the incident and updated on activities?
9. Did the State emergency management director activate the State Emergency Operations Center (EOC) and make a request to the Governor that a State emergency be declared?
10. Did the State emergency management director advise the Governor and request that a Federal emergency be declared?

Task # III-5: Direct Activation of Traffic and Access Control Points	
Outcome: Emergency Management	**Location:** EOC
Response Element: EOC Staff (Transportation)	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Evacuation order for the population at risk, selected evacuation routes, defined predicted hazard area, isolation/quarantine orders for the exposed population, and selected isolation/quarantine areas. **Conditions:** Availability of time; availability of communications systems; availability personnel; availability of vehicles, barricades, and other traffic control equipment; pertinent maps, diagrams, and plans; weather and environmental conditions; and situations at variance with assumptions in plans and procedures. **Expected Outcomes:** Traffic control points (TCPs) are in place in time to support the evacuation and/or quarantine order and facilitate an orderly evacuation, access to the predicted hazard area is prevented, and access to other areas is controlled. **Typical Steps:** 1. Review selected evacuation routes and modify as needed to mitigate any potential disruptions. Select *ad hoc* TCPs to support the evacuation routes. 2. Identify locations for access control points (ACPs) for the overall impacted area and other discrete areas requiring access control. Determine which locations are to be staffed. Ensure access control for responders. 3. Dispatch traffic and access control crews (e.g., police, fire, public works) with appropriate vehicles, equipment, and materials to specified control points. 4. Brief TCP crews on modifications to evacuation routes. Provide all evacuation support crews with appropriate maps, diagrams, and implementing instructions to mitigate any traffic flow obstacles. 5. If radiation incident, address and implement potassium iodide (KI) decisions and drivers for access control personnel as appropriate. 6. Contact appropriate government organizations or businesses to block access to the predicted hazard area by rail, water, and air traffic. 7. Coordinate traffic and access control activities with the adjacent jurisdictions. 8. Direct the repositioning of TCPs or ACPs and/or mobilizing of additional resources as changes in conditions occur. 9. Review rosters to ensure continuous 24-hour operations and assign traffic and access control personnel to tasks and shifts where they are most needed. Provide a transition or situation briefing to later shift personnel before they begin work. **Consequences:** The population at risk and the population at large is protected from exposure to agent. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*	✓ What happened? ✓ What was supposed to happen? ✓ If there is a difference, why? ✓ What is the impact of that difference? ✓ What should be learned from this? ✓ What corrective actions are recommended?

Decisionmaking

1. Did the Emergency Operations Center (EOC) transportation representative identify situations in the proposed evacuation routes that may result in traffic jams (e.g., tollbooths, railroad crossings, lane reductions, barriers)? How were the problems handled?
2. How were TCPs identified? Were they predetermined? Did they support the selected evacuation routes?
3. How were ACPs selected?
   a. What was the purpose for each ACP selected?
   b. Were ACPs identified to control access to the incident site?
   c. Were additional ACPs put in place for quarantine/isolation decisions?
   d. Were ACPs needed to control access to Strategic National Stockpile (SNS) receiving sites and distribution nodes?
   e. Were ACPs sufficient to prevent unauthorized people from entering the appropriate areas?
4. Where were sufficient TCPs (including roads, rail, airports, and seaports) established to control access/departure from the area?

Controlling Traffic and Access

5. What specific actions were taken to facilitate traffic movement? For example:
   a. Were traffic lights changed? Where and why?
   b. Were crews dispatched to clear snow or debris?
   c. Were tow trucks dispatched to locations for handling disabled vehicles and dispensing emergency gasoline supplies?
6. How was access control provided for responders (e.g., access codes, badges)?

Coordination and Communication

7. How well did the EOC communicate with traffic and access control crews? Which departments were contacted and what responsibilities did each perform?
8. Did the EOC maintain maps of ACPs?
9. How were TCP crews briefed? What information was provided? Was it sufficient?
10. Which agencies were contacted to prevent transport access to the hazard area? What actions did these agencies take to prevent access?
11. What other jurisdictions were contacted? How was this decision made? How often were these agencies provided updates?
12. How often were TCPs and ACPs repositioned? What information was used to make this decision? Who was notified of these changes (e.g., other jurisdictions)?

Task # III-6: Direct and Control Protection of At-Risk Population	
Outcome: Emergency Management	**Location:** EOC/ECC
Response Element: EOC Staff/Public Health	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Protective action decision (PAD), warning provided to the population in the impacted area, selected evacuation and restricted routes identified, and pertinent maps, diagrams, and plans. **Conditions**: Availability of time; availability of communications systems; availability of responders; availability and condition of evacuation routes; availability of transportation assets; warning information given to at-risk population; preselected traffic control points (TCPs); assembly points, and evacuation and restricted routes; and situations at variance with assumptions in plans and procedures. **Expected Outcomes:** Appropriate support is provided for protecting the population inside the impacted area or predicted health/hazard area. Only authorized personnel are within the restricted area. **Typical Steps:** 1. Obtain information from first responders on who was inside the predicted hazard area when the incident occurred. 2. Request general information on the risk analysis of the suspected agent; solicit this information if it is not provided. 3. Confirm that the population inside the predicted hazard area was alerted and given accurate shelter-in-place or evacuation instructions, using appropriate warning systems. Ensure transportation for those requiring it. 4. Coordinate evacuation routes with appropriate authorities and agencies, including other jurisdictions. 5. As appropriate, coordinate with public health to determine potential isolation/quarantine areas and identify restricted routes. Coordinate with public health to determine when it is appropriate for quarantines to be lifted. 6. Receive accountability and protection status reports from the Incident Command System (ICS) regarding the population inside the impacted area. 7. Direct and coordinate additional assistance as required. 8. Determine when it is appropriate for the sheltered population to leave their shelters and begin subsequent evacuation. 9. Monitor for changing meteorological conditions and revise decisions as needed. 10. Adjust the assembly points, restricted routes, evacuation routes, TCPs, and access control points (ACPs) to accommodate unforeseen events, and to facilitate reentry when this is authorized. **Consequences:** No unprotected persons are exposed to health hazards from the incident. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

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- ✓ What happened?
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- ✓ If there is a difference, why?
- ✓ What is the impact of that difference?
- ✓ What should be learned from this?
- ✓ What corrective actions are recommended?

Decisionmaking

1. How did the Emergency Operations Center (EOC) make decisions regarding shelter in place or evacuation?
   a. What decision was made?
   b. Who was involved in decisionmaking?
   c. How was it communicated?
2. Were isolation/quarantine orders issued?
   a. If so, when and by whom?
   b. Based on what information?
   c. Who enforced it?
3. Were any additional protective measures undertaken to prevent exposure to the agent/source/disease?
   a. If so, what were they?
   b. Were they effective?
4. How adequate were the protective actions for the nature of the agent?
5. Were decisions revised over time? If so, based on what information?

Information Dissemination and Coordination

6. What information did first responders provide on who was inside hazard area?
7. How did the EOC confirm that this population was given appropriate information?
8. Which agencies were contacted regarding coordination of evacuation routes?
9. What information was provided from the incident command post (ICP)?
10. How was information/data coordinated and communicated among response elements?
11. Was information provided to sites with special warning requirements (e.g., hospitals, schools)?
    a. Which sites?
    b. How was information provided?
    c. Was this adequate?

Task # III-7: Direct Protective Actions for Schools, Day Care Centers, and Special Populations

Outcome: Emergency Management	**Location:** EOC
Response Element: EOC Staff	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Protective action decisions (PADs) for schools, day care centers, and special populations. **Conditions:** Availability of time, availability of communications systems, information on size and location of affected populations and facilities, sheltering options for affected facilities, lists of host facilities, weather and other environmental conditions, selected evacuation and/or restricted routes, availability of transportation assets, and situations at variance with assumptions in plans and procedures. **Expected Outcomes:** All school and day care students and staff as well as special populations in at-risk areas or isolation/quarantine areas are sheltered in place or are promptly and safely evacuated to host facilities; caretakers are notified. **Typical Steps:** 1. Contact at-risk schools, day care centers, and special population facilities to inform them of the protective action to be implemented for their specific situation. Determine need for any assistance. 2. Compile resource requests and contact resource providers to obtain needed support. 3. Stage transportation assets. Brief drivers on the hazard area, routes to follow, emergency procedures, pickup points, and final destinations. 4. Coordinate with traffic control personnel to expedite movement of transportation assets to and from affected facilities. 5. Ensure that the Emergency Operations Center (EOC) notifies host schools, day care facilities, or other facilities and reception centers to prepare to receive evacuees. 6. If affected facilities were directed to shelter in place, provide appropriate assistance for implementing sheltering measures. 7. Promptly communicate changes in directed protective actions (e.g., from shelter in place to evacuation) to affected facilities. Repeat steps, as appropriate, to support the change in protective action. 8. Provide caretakers and public at large with information regarding protective actions taken, the location of host facilities, and procedures for reuniting with family members. **Consequences:** The population at risk and population at large are protected from exposure to agent. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

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Notification

1. How were at-risk facilities identified?
   a. What information was used?
   b. How was it provided and by whom?
   c. Was the information accurate?
2. Who performed initial contact with these special populations?
   a. What information were the sites provided (e.g., shelter in place, evacuate)?
   b. How were their needs assessed?

Support

3. How was transportation coordinated?
   a. Who was involved in obtaining appropriate transportation assets?
   b. Who directed them to the appropriate locations?
   c. What information were drivers provided regarding their responsibilities?
4. How were host facilities identified?
   a. What information were they provided?
   b. Who provided the information?
5. How were the caretakers of the affected population notified? What information were they provided?
6. How were any changes in decisions communicated to those affected?

Task # III-8: Direct and Control Distribution of Supplies and Equipment	
Outcome: Emergency Management	**Location:** Incident Site/EOC
Response Element: ICS/UCS/EOC Staff	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Agent contamination remaining at and around the incident site following release control operations, and other contaminated equipment, supplies, and materials. **Conditions:** Availability of time; conditions at the incident scene; availability of communications systems; availability of trained workers; availability of equipment and supplies; and plans, procedures, and regulations regarding mitigating the effects of an agent release. **Expected Outcomes:** Sufficient equipment, vehicles, and supplies are available to control and mitigate the release or provide disease or health impact protection, and to perform related support tasks. **Typical Steps:** 1. Dedicate available supplies, equipment, and vehicles to support release control and mitigation operations at the incident site or to support disease control and mitigation operations. 2. Test, inspect, and repackage supplies and equipment for issue to response teams. 3. Issue supplies to responders on demand. 4. For biological incidents, monitor transportation and staging activities at the Receiving, Staging, and Storage (RSS)/Forward Control Point (FCP) and distribution nodes, and coordinate requests for additional resources. 5. Track supply and equipment usage rates to forecast rates of issue and to accurately account for costs associated with the response. Factor contamination losses for durable and nonexpendable supplies and equipment used at the incident site when compiling usage rates. Report high supply and equipment issue rates to the EOC logistical staff. 6. Maintain contaminated vehicles for reuse in the hazard zone. 7. Have equipment and vehicles identified for release control and mitigation operations prepared for use by motor pool or facility engineer personnel. **Consequences:** Release control and mitigation operations are sustained for the duration of response to the incident. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

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- ✓ What happened?
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- ✓ If there is a difference, why?
- ✓ What is the impact of that difference?
- ✓ What should be learned from this?
- ✓ What corrective actions are recommended?

Coordination

1. Were appropriate procedures in place to:
   a. Locate and acquire appropriate equipment and supplies?
   b. Distribute equipment and supplies?
   c. Account for equipment and supply usage?
2. Was the resource allocation plan applied appropriately?
3. How were equipment/supply priorities established?
4. How was equipment usage tracked? What information was provided and by whom?

Supplies and Equipment

5. Was the equipment that was requested adequate for the response?
6. Was the needed equipment available?
7. Was any equipment that was available not used?

Task # III-9: Request and Coordinate Additional Response Support	
Outcome: Emergency Management	**Location:** EOC
Response Element: EOC Staff	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Reports from the incident scene, incident command post (ICP), or affected areas identifying the need for personnel, supplies, and equipment for response operations. **Conditions:** Availability of communications systems, availability of responders, availability of supplies and equipment, MOAs with other response and/or health and medical organizations, and plans and procedures. **Expected Outcomes:** Sufficient personnel, equipment, and supplies are available for response, recovery, and mitigation operations and to perform related support tasks. **Typical Steps:** 1. Solicit information about usage rates for supplies and equipment from the ICP and other requesting entities. 2. Compare inventory of available supplies and equipment with known and projected requirements to support response, containment, mitigation, and treatment operations. Identify shortfalls and priorities. Determine the most expedient sources for obtaining needed supplies and equipment. 3. Solicit information about the need for additional trained responders and resources above and beyond those available from jurisdiction resources. Determine shortfalls and priorities. Determine the most expedient sources for obtaining additional resources. 4. Obtain responders and emergency supplies and equipment from the State or adjacent jurisdictions through Emergency Management Advisory Council (EMAC), or Federal or private vendors. 5. Arrange for the receipt and internal distribution of supplies and equipment to sustain response operations. 6. Arrange for the arrival, transportation, feeding, and lodging of augmentees. Assign augmentees to tasks and shifts. **Consequences:** Response operations are sustained for the duration of response to the incident. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

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- ✓ What is the impact of that difference?
- ✓ What should be learned from this?
- ✓ What corrective actions are recommended?

Equipment and Support Needs

1. What information did the ICP provide about usage rates?
   a. What equipment was being used most frequently?
   b. How often were updates on usage provided?
2. How was equipment inventory analyzed?
   a. Where did inventory information come from?
   b. How were projected equipment needs determined?
   c. Who determined where shortfalls existed?
   d. How was this analysis done?
3. What additional equipment or support was needed?
   a. Were these supplies that were not typically available (e.g., for radiological incidents, were portal monitors and whole body monitors requested)?
   b. What type of specialized response support was requested?

Procurement and Distribution

4. How did the EOC identify sources of additional equipment and responders?
   a. Where did the additional equipment/responders come from (e.g., adjacent jurisdiction, State)
   b. Were plans and procedures in place for procuring and distributing such equipment?
   c. Were these effective?
5. How were priorities for distributing additional equipment made?
6. How were resource requests compiled and allocation decisions made?
7. Were State agencies and volunteer organizations used to assist counties?

Task # III-10: Request State/Federal Assistance	
Outcome: Emergency Management	**Location:** EOC
Response Element: EOC Staff	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Need for additional personnel, supplies, and equipment for response operations; 42 US Code 68 (Disaster Relief); and memorandums of agreements (MOAs)/memorandums of understanding (MOUs) with other jurisdictions, organizations, and Emergency Management Advisory Council (EMAC) for provision of emergency personnel, supplies, and equipment. **Conditions:** Availability of trained responders and inventory of supplies and equipment versus requirements. **Expected Outcomes:** Local and State declarations of emergency are prepared, signed, and transmitted to higher authorities. Sufficient personnel, equipment, and supplies are made available. **Typical Steps:** 1. Identify any shortfalls in personnel, emergency supplies, equipment, or other resources that affect ability to respond to the emergency. 2. In conjunction with appropriate emergency management officials, confirm that effective response is beyond local capability and that additional assistance is necessary. 3. Follow plans and procedures, and provide support as needed, for declaring an emergency at the local and State levels. 4. Identify specific State and Federal assistance that is needed, and follow appropriate plans and procedures for requesting such assistance. 5. As appropriate, execute MOUs/MOAs with other jurisdictions. **Consequences:** Hazard is mitigated because appropriate assistance and resources become available. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*

- ✓ What happened?
- ✓ What was supposed to happen?
- ✓ If there is a difference, why?
- ✓ What is the impact of that difference?
- ✓ What should be learned from this?
- ✓ What corrective actions are recommended?

1. Describe the process for determining that the incident exceeds local capability?
   a. Who was involved in this analysis?
   b. What information was used to support this determination?
   c. Were emergency managers aware of outside assistance from Federal and State levels that could assist in the emergency response?
2. What specific assistance was identified as being needed?
   a. What equipment was needed?
   b. What expertise or specialized teams were needed?
3. Did the emergency management director request (from the State) that the State Emergency Operations Center (EOC) be activated and a State emergency be declared?
   a. Were there plans and procedures for this and were they followed? Were they adequate?
   b. Were the State and county advised of the local declaration and updated on the city's activities?
4. Were notifications made to appropriate Federal agencies such as the U.S. Department of Homeland Security?
5. Were there plans and procedures for requesting Federal assistance, and were they adequate?

Task # III-11: Direct and Control Critical Infrastructure Mitigation	
Outcome: Emergency Management	**Location:** EOC
Response Element: EOC Staff/Public Works	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Reports from the incident scene or incident command post (ICP) identifying the need for personnel, supplies, and equipment for debris removal, infrastructure stabilization, and damage assessment. **Conditions:** Availability of communications systems, availability of public works staff, availability of supplies and equipment, knowledge of plans and procedures, and knowledge of plans and procedures for contaminated equipment. **Expected Outcomes:** Sufficient personnel, equipment, and supplies are available for debris removal, damage assessment, and infrastructure stabilization and to provide mapping and perform related public works support tasks. **Typical Steps:** 1. Establish priorities to clear and secure roads, repair damaged water/sewer systems, and coordinate the provision of temporary, alternate, or interim sources of emergency power and water/sewer services. 2. Identify water and sewer service, restoration, debris management, potable water supply, and engineering requirements as soon as possible. 3. Identify commercial or public facilities that pose a risk if left unattended. 4. Evaluate status of current resources to support public works operations. 5. Allocate existing and available resources. 6. Request additional resources as needed. 7. Accurately account for costs associated with response. 8. Begin damage assessment for recovery. 9. Identify equipment exposed to agent for decontamination. **Consequences:** Direction and control of critical public works operations are provided for duration of jurisdiction's response. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*	✓ What happened? ✓ What was supposed to happen? ✓ If there is a difference, why? ✓ What is the impact of that difference? ✓ What should be learned from this? ✓ What corrective actions are recommended?

Notification

1. Why was public works notified?
   a. By whom?
   b. What preliminary information was given?
   c. What specific activities were to be conducted by public works?
2. Did public works personnel arrive in a timely manner?
3. What facilities (if any) were identified as posing a risk if left unattended?

Response

4. What type of resources or assistance did public works provide?
   a. What specific activities did they undertake (e.g., debris removal, disposal of contaminated materials, damage assessment)?
   b. Was appropriate equipment/resources brought on scene?
   c. Were public works personnel able to apply the appropriate equipment?
   d. Did they recognize the capability and limitations of the equipment?
5. Were activities carried out in a safe and efficient manner?
   a. Were precautions, safeguards, or any additional coordination implemented to protect responders from contamination?
   b. How was contaminated material disposed of?
   c. How was evidentiary integrity of debris and contaminated debris maintained? Was it maintained to an appropriate degree?
   d. Was damage assessment conducted according to standard procedures?
6. For all activities, were plans and procedures in place to ensure worker safety?
7. Was public works able to maintain essential utility services (e.g., electrical, water)?
8. How was coordination among responding public works assets organized?
   a. Was the response coordinated efficiently?
   b. What methods could have been incorporated that would have improved these efforts?

Task # III-12: Direct and Control Public Information Activities

Outcome:	Emergency Management	**Location:**	EOC
Response Element:	EOC/PIO	**Jurisdiction:**	
Evaluator:		**Contact #:**	

Task Information	Notes
Inputs: Reports describing the incident, information regarding the State's response, other emergency information, and broadcast and published media reports. **Conditions:** Availability of communications systems, impact of the incident statewide, location of the Joint Information Center (JIC), availability of safe routes to the JIC, availability of public information staff, plans and procedures for emergency public information programs, memorandums of agreement (MOAs), and procedures for using a Joint Information System (JIS) and for activating and operating a JIC. **Expected Outcomes:** The JIC is activated and operated in accordance with established protocols and without interruptions in providing timely and accurate emergency information to the public. **Typical Steps:** 1. The Public Information Officer (PIO) and public information staff conduct initial public information activities from the EOC or other designated area(s). 2. The PIO coordinates with PIOs from other agencies to determine their ability to support, activate, and operate the JIC. The PIO advises the Emergency Medical Director (EMD) on the status of public information and makes recommendations for activating the JIC. 3. The EMD directs the activation of the JIC (see Task III-13). 4. The EMD assigns the PIO and/or public affairs to the EOC and the JIC, according to staff availability, response priorities, and the JIC plan. The EMD provides the necessary subject matter experts to the JIC. 5. The PIO announces the shift of focus for the jurisdiction's public information activities from the Emergency Operations Center (EOC) to the JIC (once it is activated and operating). 6. The PIO and/or public affairs staff keep the EMD informed about JIC operations, so that the direction and control of public information activities can be adjusted to suit circumstances. **Consequences:** The public receives accurate and timely information about the incident. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*	✓ What happened? ✓ What was supposed to happen? ✓ If there is a difference, why? ✓ What is the impact of that difference? ✓ What should be learned from this? ✓ What corrective actions are recommended?

Communications Plan

1. Was a single media point of contact established early in the incident? Who and where?
2. Was a media conference area established? Was the need for regular briefings and information releases recognized and acted upon? Who provided the briefings?
3. How did the agencies involved prepare and coordinate news releases for dissemination and/or conduct press conferences for the local media?
4. What actions were taken within dispatch to handle public inquiries?
5. What procedures were used to ensure essential incident information was provided to the PIO?
6. How was the media plan developed? Was it implemented in an effective and timely manner?

Public Information Dissemination

7. What procedures were used to publicly disseminate information?
8. What information was provided to the public to educate them about potential hazards and risk reduction methods?
9. How was use of the Emergency Alert System (EAS) coordinated to disseminate information to the public?
10. How did the media plan use media outlets to keep the public informed?

Agency Coordination Protocols

11. Were updates given to supporting agencies/organizations? How often were updates provided?
12. Were preprinted public information protocols and materials prepared and available?
13. How was critical/sensitive information disseminated to agencies (e.g., in person, by telephone, by radio)?
14. What measures were taken to coordinate with the Governor's press secretary on a recurring basis?
15. How was coordination established with the myriad of Federal and State agencies before their inclusion in the JIC?
16. What measures were taken to ensure a common government message? Were all press briefings done by a single media contact?
17. Was a JIC established? Why or why not?

Task # III-13: Activate and Operate Joint Information Center	
Outcome: Emergency Management	**Location:** JIC
Response Element: JIC	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Decision to activate the Joint Information Center (JIC). **Conditions:** Availability of communications systems; impact of incident on community; location of JIC; availability of safe routes to the JIC; availability of public information staff; plans and procedures for emergency public information programs; memorandums of agreements (MOAs); plans and procedures for activating and operating a JIC; and availability of JIC facilities, supplies, and equipment. **Expected Outcomes:** A JIC fully capable of performing all emergency public information operations is established. There is a continual flow of information between the JIC, the respective Emergency Operations Centers (EOCs), and other participating response organizations; interruptions in providing timely and accurate emergency public information do not occur. **Typical Steps:** 1. Open the JIC. 2. Inform EOC and other appropriate authorities that the JIC is operational and that direction and control of public affairs/public information activities have shifted from the EOC to the JIC. 3. Promptly post response information in the JIC. Archive this information for subsequent analysis, investigations, and preparation of official reports. 4. Plan for and maintain uninterrupted 24-hour operations to include publication of schedules that cover all shifts with adequate staff. 5. Provide the media with briefings on significant events in a coordinated, complete, accurate, and timely manner. 6. Monitor media reports for accuracy to identify items that may cause a misunderstanding of emergency instructions to the public or that misrepresent the response. Contact the media to amplify, clarify, or correct information. 7. Arrange use of a facility for media briefings. 8. Maintain a log of all media inquiries. **Consequences:** Information disseminated to the public is coordinated and consistent, the credibility of public authorities and public confidence in their ability to respond to the incident are not compromised, and JIC operations are sustained for the duration of the response to the incident. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*

- ✓ What happened?
- ✓ What was supposed to happen?
- ✓ If there is a difference, why?
- ✓ What is the impact of that difference?
- ✓ What should be learned from this?
- ✓ What corrective actions are recommended?

JIC Activation

1. What factors drove the establishment of a JIC?
2. Did public information staff report to the EOC or JIC in a timely manner?
3. What agencies and organizations were represented in the JIC?
4. Were any agencies missing that should have been included in the JIC? Who and why?
5. What local procedures were followed to establish a JIC?
6. Discuss which agency had the lead and who had final policy and decision authority over the JIC (e.g., director of emergency management, mayor, city manager).

JIC Operation

7. How was the location of the JIC determined? How was information disseminated to agencies and media?
8. Was the JIC organized to effectively execute its role? Were supporting agencies adequately staffed and equipped to perform their functions in the JIC?
9. What plans have been developed to support a JIC expansion to accommodate Federal and State involvement?
10. What actions were taken to set criteria for and control of access to the JIC?
11. How was coordination established with the myriad of Federal and State agencies before their inclusion in the JIC?
12. Did media and public affairs personnel report to the EOC or JIC in a timely manner?
13. What was the procedure for the approval of press releases? Who had final approval authority?
14. Were public messages correct and consistent among JIC staff and remote public information staff?
15. What messages were inconsistent? Why? What was the impact?

JIC Staffing and Equipment

16. What volume of calls (media and public) did the JIC have to manage?
17. How adequate was the staffing in relation to the call volume and the need to prepare press releases and briefings?
18. How adequate was the equipment provided (computers, fax, copiers, telephones, etc.) to manage the volume of public and media inquiries?

Task # III-14: Provide Emergency Public Information to Media and Public	
Outcome: Emergency Management	**Location:** EOC/JIC
Response Element: EOC Staff/JIC	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Reports describing incident/outbreak, information regarding the State's response, protective action decisions (PADs) or other emergency information, and broadcast and published media reports. **Conditions:** Availability of communications systems, impact of incident on community, location of Joint Information Center (JIC), availability of public information staff, plans and procedures for emergency public information programs, memorandums of agreement (MOAs), and procedures for activating and operating a JIC. **Expected Outcomes:** Information is shared among the JIC, the respective Emergency Operations Centers (EOCs), and other participating response organizations. Prompt, accurate, consistent, and responsive emergency information is provided to the public. **Typical Steps:** 1. Gather information about the incident, the response, and emergency information to be provided to the public. 2. Prepare media releases to provide the public updated or new emergency information. 3. Coordinate the content of the media releases prior to dissemination. 4. Disseminate media releases according to plans and procedures. 5. Spokespersons from appropriate agencies provide the media with briefings on significant events in a coordinated, complete, accurate, and timely manner. 6. Monitor media reports for accuracy to identify incorrect or inaccurate items. Contact the media to amplify, clarify, or correct information. 7. Prepare materials for, announce, and conduct media briefings. 8. Reply to media inquiries with coordinated, authorized information that is accurate, clear, and complete in a timely manner. 9. Maintain a log of all media inquiries. 10. Provide prompt, accurate, consistent, and responsive emergency information. 11. Track rumors or misinformation from either media accounts or the public and bring to the attention of Public Information Officer (PIO) for clarification and correction as appropriate. **Consequences:** Populations potentially at risk are provided accurate and timely information to allow implementation of protective actions. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*

- ✓ What happened?
- ✓ What was supposed to happen?
- ✓ If there is a difference, why?
- ✓ What is the impact of that difference?
- ✓ What should be learned from this?
- ✓ What corrective actions are recommended?

Information Gathering and Analysis

1. How did the public information staff gather and share essential incident information from the response organization?
2. How did the public information staff gather information from the public and media to ensure that their message was being properly received?
3. What trends in media reporting were identified and provided to the PIO and emergency management officials?
4. What trends in public inquiries and rumors were identified and provided to the PIO and emergency management officials?

Public Information Dissemination

5. What procedures were used to publicly disseminate information? Were these procedures adequate?
6. How frequently were press releases issued?
7. What information was provided to the public to educate them about potential hazards and risk reduction methods?
8. How was this information checked with technical experts to ensure it was accurate before release?
9. What procedures were used for press release approval?
10. How was use of the Emergency Alert System (EAS) coordinated to disseminate information to the public?
11. How did the media plan use media outlets to keep the public informed?
12. For a biological incident, were directions provided to the population on where to go and what to do for disease protective measures, quarantine, isolation, prophylaxis, and vaccination? Were they updated regularly?
13. What trends in media reporting were identified and provided to the PIO and emergency management officials?
14. What trends in public inquiries and rumors were provided to the PIO and emergency management officials?

Agency Coordination Protocols

15. Were progress reports given to all agencies where necessary? How often and by whom?
16. Were updates given to supporting agencies/organizations? How often were updates provided?
17. How was critical/sensitive information disseminated to agencies (e.g., in person, by telephone, by radio)?
18. What measures were taken to coordinate with the Governor's press secretary on a recurring basis?
19. How was coordination established with the myriad of Federal and State agencies before their inclusion in the JIC?
20. What measures were taken to ensure a common government message?
21. Was a JIC established? Why or why not?

EOC and JIC Operations

22. How did the lead PIO or JIC activate a rumor control (public inquiry) center?
23. How was the location of the JIC determined and information disseminated to agencies and media?
24. Was the JIC organized to effectively execute its role? Were supporting agencies adequately staffed and equipped to perform their functions in the JIC?
25. What actions were taken to set criteria for and control of access to the JIC?
26. How was the media plan developed? Was it implemented in an effective and timely manner?

Task # III-15: Establish and Maintain Rumor Control Operations	
Outcome: Emergency Management	**Location:** JIC
Response Element: PIO	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Reports describing the biological incident/outbreak, information regarding the States' response, protective action decision (PAD) or other emergency information, and broadcast and published media reports. **Conditions:** Availability of communications systems, impact of the incident on the community, location of the Joint Information Center (JIC), availability of public information staff, plans and procedures for emergency public information programs, memorandums of agreement (MOAs), and procedures for activating and operating a JIC. **Expected Outcomes:** Public information is delivered in a coordinated and timely manner. Public inquiries are handled with a consistent unified response. **Typical Steps:** 1. Set up rumor control operation consisting of volunteers trained to handle incoming calls from concerned public. 2. Provide scripted message to rumor control staff and conduct staff briefing. 3. Provide to public, via media outlets, the telephone number for inquiries regarding incident. 4. Ensure that rumor control staff work 24/7 in shifts, taking calls from public. Update staff regularly as situation changes. 5. Monitor media reports for accuracy to identify incorrect or inaccurate items. Contact the media to amplify, clarify, or correct information. 6. Track rumors or misinformation from either media accounts or the public and bring to the attention of the Public Information Officer (PIO) for clarification and correction as appropriate. **Consequences:** Rumors or misinformation from either media accounts or the public is tracked and brought to the attention of PIOs and is corrected as appropriate. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*	✓ What happened? ✓ What was supposed to happen? ✓ If there is a difference, why? ✓ What is the impact of that difference? ✓ What should be learned from this? ✓ What corrective actions are recommended?

1. How did the lead PIO or JIC activate the rumor control center?
2. How was the rumor control hotline established? Was a rollover phone bank used to handle large call volume?
3. What rumors were detected and corrected?
4. What rumors were not detected or not corrected?
5. What impact did the rumors have on response operations?

Task # III-16: Activate and Operate Public Health Emergency Coordination Center	
Outcome: Emergency Management	**Location:** ECC
Response Element: Public Health	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Decision to activate the Public Health Emergency Coordination Center (ECC) and ECC staff mobilization. **Conditions:** Current facility operating status, time available for public health staff to respond to the ECC, availability of needed equipment and facilities, communications systems availability, ECC staff availability, and knowledge of plans and procedures. **Expected Outcomes:** The ECC achieves its full operational status quickly and maintains this level of effort for the duration of the response. **Typical Steps:** 1. Upgrade facility from current to emergency status: a. Follow procedures for removing equipment from storage locations. b. Ensure equipment is operating properly. c. Prepare facility for emergency use. d. Review plans and procedures appropriate for the incident. 2. Confirm that public health communications systems (primary, backup, and alternate) are operational. Maintain an uninterrupted capability for the duration of the response. Immediately correct communications system malfunctions. 3. Brief ECC staff members on the status of the incident and current response activities upon their arrival and at regular intervals thereafter. 4. Provide coordination of public health response activities. 5. Establish and maintain security throughout the response. 6. Promptly post information about the situation and decisions in the ECC. Archive information for subsequent analysis, investigation, and preparation of official reports. 7. Plan for 24-hour operations to include publication of schedules or on-call lists that cover all shifts with adequate staff. 8. Maintain continuous ECC operations during rest, meal breaks, and shift changes. Conduct shift transition briefings in accordance with plans and procedures. 9. Ensure communications/coordination with the Emergency Operations Center (EOC), field operations, and local governments. **Consequences:** Direction and control of critical response operations are performed without interruptions caused by lapses in public health staffing, communications systems malfunctions, or facility shortfalls. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*

- ✓ What happened?
- ✓ What was supposed to happen?
- ✓ If there is a difference, why?
- ✓ What is the impact of that difference?
- ✓ What should be learned from this?
- ✓ What corrective actions are recommended?

ECC Activation

1. What agencies were notified about the ECC location and how? Was this list sufficient?
2. Were current listings of key personnel and their telephone numbers for ECC activation available and used? What procedures were established to ensure the list(s) were current?
3. Were the participants you observed stopped and identified prior to entering the ECC? How was this conducted?
4. Were copies of the public health emergency plans and procedures made available to all ECC personnel? When was this plan last updated?

Roles and Responsibilities

5. Who assumed control of ECC operations (e.g., public health operations officer or designated alternate)?
6. Did the public health operations officer have authority to use necessary resources to mitigate the emergency and coordinate additional elements?
7. What liaisons from participating agencies/departments were present at the ECC?
8. Did the liaisons have decisionmaking authority for their respective agencies? If not, who had this authority?
9. Was the ECC organized by functions according to the Emergency Operations Plan (EOP)? What were the functional areas activated in the ECC?
10. Was the activation and response coordinated and efficient?
11. Were the agencies/departments you observed properly equipped to perform their functions? Please list any missing tools.
12. Was a determination of incident stabilization and termination of command made? How and by whom?
13. Were procedures established to maintain a communications link or liaison with the EOC, local public health agencies, and the ECC?

Task # III-17: Request Strategic National Stockpile Supplies	
Outcome: Emergency Management	**Location:** EOC
Response Element: Executive Management Team	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Identification of actual or potential health problem that may threaten the health of the community and concern that need will exceed local resources. **Conditions:** Availability of time; availability of trained emergency responders, health, and medical personnel; emergency plans and procedures; and conditions at variance with plans and procedures. **Expected Outcomes:** Confirmation of need for Strategic National Stockpile (SNS), decision to request SNS, use of State and local procedures to request SNS, and determination by the Centers for Disease Control and Prevention (CDC) to provide SNS. **Typical Steps:** 1. Local officials (e.g., mayor's officer, emergency management, law enforcement, public heath, fire/hazardous materials [HazMat]) identify problem that may require need to request SNS. 2. Local officials notify State emergency management or public health of potential need for SNS. 3. State and local officials consult and confer to determine need for SNS request. 4. Authorized state official requests deployment of SNS from CDC via the CDC 24-hour emergency response number. 5. CDC initiates conference calls to State and local officials and Federal partners to discuss threat/incident conditions, State and local response capability, and sustainability of local response resources. 6. CDC makes decision to deploy SNS and requests State SNS management plan. **Consequences:** Efficient decisionmaking leads to timely deployment of SNS supplies. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

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- ✓ What happened?
- ✓ What was supposed to happen?
- ✓ If there is a difference, why?
- ✓ What is the impact of that difference?
- ✓ What should be learned from this?
- ✓ What corrective actions are recommended?

1. What triggered the SNS request?
   a. Overt release of agent?
   b. Intelligence or law enforcement claim of actual release or potential attack?
   c. Clinical or epidemiological indications?
   d. Unexplainable increase in emergency medical services (EMS), antibiotics, or over-the-counter medications?
2. Which local officials were involved in the initial discussions?
3. What assessment process or checklist was used to determine the need for SNS?
   a. Was this process delineated in local plans/procedures?
   b. Was the information needed to justify the request easily obtained?
4. What local resource considerations were taken into account in determining need for SNS?
   a. Number of casualties?
   b. Population considerations?
   c. Hospital capacity?
   d. Other local resources (e.g., pharmacy distributors, oxygen availability, transport capacity)?
   e. State resources?
   f. Status of local SNS plans?
5. What is the estimated risk at the time of the request?
   a. How many people have been exposed?
   b. How many people were symptomatic (known infected)?
   c. What was the estimate of the total risk (potential exposed and future disease transmission)?
6. Which state official(s) made the SNS request?
7. What information was used by CDC to make the determination to provide SNS?

Task # III-18: Activate and Direct Strategic National Stockpile Supply Network			
Outcome:	Emergency Management	**Location:**	EOC/RSS
Response Element:	EOC/Public Health	**Jurisdiction:**	
Evaluator:		**Contact #:**	

Task Information	Notes
Inputs: Centers for Disease Control and Prevention (CDC) decision to deploy 12-hour push package/Vendor Managed Inventory (VMI) and determination of local areas to receive materiel. **Conditions:** Availability of time, availability of trained Strategic National Stockpile (SNS) distribution and dispensing personnel, emergency plans and procedures, and conditions at variance with plans and procedures. **Expected Outcomes:** Key individuals, support agencies, organizations, and personnel are notified of arrival of SNS materiel. **Typical Steps:** 1. Confer with CDC SNS transport to determine delivery method and location. 2. Activate all SNS distribution system functions: a. Identify and activate Receiving, Staging, and Storage (RSS) security, loading/unloading, and repackaging teams. b. Identify and activate designated transportation providers (e.g., motor truck associations, U.S. Department of Transportation [DOT], National Guard [as listed in plans]). c. Coordinate activation of distribution nodes prior to SNS dispatch from RSS. 3. Based on identification of areas to receive SNS, identify number and location of actual dispensing sites and treatment centers. 4. Coordinate activation of designated dispensing sites prior to dispatch of SNS supplies from distribution nodes. 5. Set up inventory management system and identify items and quantities that will arrive. 6. Alert other functions (e.g., law enforcement/security, communications) that will support SNS team. 7. Monitor inbound progress and estimated time of arrival of SNS. 8. Confirm security and communications for moving SNS from landing location to RSS. 9. Before SNS arrives, acquire local inventories to protect essential personnel. Administer prophylaxis/vaccination to essential personnel. **Consequences:** SNS supplies are received and delivered to dispensing sites with no delays. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*

- ✓ What happened?
- ✓ What was supposed to happen?
- ✓ If there is a difference, why?
- ✓ What is the impact of that difference?
- ✓ What should be learned from this?
- ✓ What corrective actions are recommended?

Notification and Activation of Distribution System

1. Who was responsible for contacting the various elements of the SNS distribution system function?
2. How was the activation process conducted (e.g., telephone)?
   a. Was this process clearly delineated in the plans and procedures?
   b. Was this process effective?
3. Were all necessary staff notified of SNS deployment?
   a. RSS security? Loading/unloading? Repackaging teams?
   b. Distribution nodes?
   c. Transportation?
   d. Security?
4. How many staff were activated for each function? Was this adequate?
5. Was each function notified within a timely manner?
6. What other functions were notified and why?

Identification and Activation of Dispensing Sites

7. Who made determination of where dispensing sites would be located?
8. How was this determination made?
   a. How was this coordinated with activities to identify areas in need and allocation of supplies?
   b. How were specific facilities selected (e.g., size, ease of access, adequate parking, adequate bathrooms, loading areas, easy to drive or walk to)?
   c. How did public health balance the convenience of having more sites (to serve more patients) with the need for more health care professionals, more security, and so on?
9. How were dispensing sites activated?

Identification of Arrival Location

10. What was the proposed arrival location for CDC delivery of SNS materiel?
    a. How was this location determined?
    b. Who made the decision?
    c. Were all parties in agreement?
11. Was this an appropriate choice?
    a. Could the selected location handle a wide-bodied jet?
    b. Was it a secure location?
    c. Did the selected location have the appropriate equipment?
    d. How many people were involved?
12. Was there a backup plan for an alternative dispensing site?

Task # III-19: Direct and Control Strategic National Stockpile Operations	
Outcome: Emergency Management	**Location:** EOC/Public Health
Response Element: Public Health	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Centers for Disease Control and Prevention (CDC) deployment of Strategic National Stockpile (SNS) materiel, Public Health Emergency Coordination Center (ECC) activation, and activation and operation of SNS distribution system and functions. **Conditions:** Availability of communications systems; an operations management team comprising staff with medical materiel management, contract and purchasing, communications, and security skills; and plans and procedures for SNS operations. **Expected Outcomes:** Command and control of the SNS distribution process are managed in an efficient manner, from receipt to final recovery of SNS assets. **Typical Steps:** 1. Establish command structure for managing SNS operations (e.g., Incident Command System [ICS]). 2. Monitor and coordinate the effort of each SNS functional area (e.g., receiving, packaging, delivery, dispensing) and receive updates on the status of these activities. 3. Provide security for SNS staff, processes, equipment, and materiel. 4. Direct and oversee inventory control function: a. Monitor receipt of SNS materiel and equipment. b. Process requests from dispensing sites and treatment centers. c. Apportion available SNS inventory when requests exceed available supply. d. Monitor stock levels and work with CDC Technical Advisory Response Unit (TARU) to replenish materiel. 5. Coordinate with Emergency Operations Center (EOC) to request support from other response functions (e.g., law enforcement). 6. Track location where materiel and equipment are sent. 7. Provide updated report to EOC regarding activities at dispensing sites. 8. Recover unused materiel and assets. **Consequences:** Appropriate populations receive SNS materiel in a timely manner to prevent further outbreak of disease. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*	✓ What happened? ✓ What was supposed to happen? ✓ If there is a difference, why? ✓ What is the impact of that difference? ✓ What should be learned from this? ✓ What corrective actions are recommended?

Inventory Control

1. How were requests from dispensing sites/treatment centers/medical centers received?
2. How were they processed?
3. Did the inventory control staff produce an issue document?
4. How were materiel requests communicated to Receiving, Staging, and Storage (RSS)? To the distribution nodes?
5. How was materiel replenished when needed?
6. How did the inventory control staff track materiel sent?
7. Were other medical supplies requested? If so, what were they and how long did it take?

Coordination and Communication

8. How did this management function monitor and coordinate the activities of the different functions?
9. How did the SNS management function work with the CDC TARU?
10. How was this information communicated to the EOC?
11. What other requests for support were received? How were they addressed?

Recovering Assets

12. How were unused materiel and assets identified?

Task # III-20: Direct and Control Public Health Information Activities	
Outcome: Emergency Management	**Location:** EOC/Public Health
Response Element: Public Health	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Reports describing the incident, information regarding the State's response, public health emergency information, safe health and safety practices, protective action recommendations (PARs), and broadcast and published media reports. **Conditions:** Availability of communications systems, impact of biological incident/outbreak statewide, trained public health professional availability, public information staff availability, plans and procedures for emergency public information programs, memorandums of agreement (MOAs), and procedures for operation of public inquiry hotline. **Expected Outcomes:** The public inquiry hotline is activated and operated in accordance with established protocols and MOAs and without interruptions, providing timely and accurate emergency information to the public. **Typical Steps:** 1. The Public Information Officer(s) (PIO[s]) and public information and mental health advisors' staff conduct initial public information activities from public health. 2. The Emergency Operations Center (EOC) and/or PIO advises public health on the status of public information, and make recommendations for activating the public inquiry hotline. 3. Public health coordinates with the PIO to activate the public information hotline. 4. Hospitals are notified that information hotline is activated. 5. Public health assigns a PIO and/or public affairs to the designated location for operating the public inquiry hotline, according to staff availability, response priorities, and the Joint Information Center (JIC) plan. 6. The PIO announces that all calls referencing general public health-related questions will be addressed through the public inquiry hotline, once it is activated and operating. 7. The PIO and/or the public affairs staff keep public health informed about hotline operations so that the direction and control of public information activities can be adjusted to suit circumstances. 8. Local and State public health entities should coordinate for a consistent message. **Consequences:** The correct populations identify themselves as in danger and comply with recommended protective actions; the credibility of public authorities and public confidence in the EOC is maintained. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*

- ✓ What happened?
- ✓ What was supposed to happen?
- ✓ If there is a difference, why?
- ✓ What is the impact of that difference?
- ✓ What should be learned from this?
- ✓ What corrective actions are recommended?

Information Collection and Dissemination

1. Were progress reports given to all agencies where necessary? How often and by whom?
2. Was a media conference area established? Was the need for regular briefings and information releases recognized and acted upon? Who provided the briefings?
3. What trends in media reporting were identified and provided to the PIO and emergency management officials?
4. What trends in public inquiries and rumors were identified and provided to the PIO and emergency management officials?

Public Health and JIC Operations

5. Did media and public affairs personnel report to public health in a timely manner?
6. What local procedures were followed to establish a public inquiry hotline?
7. How did the lead public health operations officer or PIO activate a rumor control (public inquiry) center?
8. How was the location of the public inquiry hotline determined and information disseminated to agencies and media?
9. Was the public inquiry hotline organized to effectively execute its role? Were supporting agencies adequately staffed and equipped to perform their functions in the JIC?
10. What plans have been developed to support a JIC expansion to accommodate Federal multi-State agency involvement?
11. What actions were taken to set criteria for and control of access to the public inquiry hotline?

Information Provided to Public

12. What information was provided to the public:
    a. Regarding the agent and its threat to the public?
    b. On dispensing locations and treatment centers?
    c. On reasons for using the medication, the importance of following the regimen, and the dangers of overmedicating?
    d. On quarantine/isolation?
13. Was this information updated regularly?

Task # III-21: Establish and Maintain Public Health Information Line	
Outcome: Emergency Management	**Location:** EOC/Public Health
Response Element: Public Health	**Jurisdiction:**
Evaluator:	**Contact #:**

Task Information	Notes
Inputs: Reports detailing the State's public health-related protective action decisions (PADs), protective action recommendations (PARs), public health emergency information, and safe health and safety practices. **Conditions:** Availability of communications systems, impact of the biological incident/outbreak statewide, trained public health professional availability, public information staff availability, plans and procedures for emergency public information programs, memorandums of agreement (MOAs), and procedures for operation of public inquiry hotline. **Expected Outcomes:** Demonstrate the capability to establish and operate rumor control (public inquiry) in a coordinated and timely manner. Ensure that public inquiries are handled with a consistent unified response. **Typical Steps:** 1. Public health establishes a rumor control (public inquiry) information line operation to handle incoming calls from concerned public. 2. Provide scripted message and conduct briefing for each rumor control (public inquiry) staff member. 3. Provide public information line telephone number via media outlets. 4. Rumor control (public inquiry) staff works 24/7 in shifts, taking calls from public, and is updated regularly as situation changes. 5. Rumor control (public inquiry) staff advises the Public Information Officer (PIO) of trends in rumors based on incoming telephone calls or monitoring of media reporting. **Consequences:** Incorrect information is corrected. Trend information on the questions from the general public is relayed to public health. Inaccuracies or clarification obtained from the questions is included in the next media release. ***Note: These are "typical" steps that you might expect to see a player carry out when performing this task. Please consult the specific jurisdiction's plans and procedures for actual requirements.***	*Record time task starts and is completed. Describe any actions that appear to significantly help or impede achievement of the outcome.*

Followup Analysis

*Upon completion of the day's exercise play, evaluators should compile their observations into a chronological narrative of events, describing outcomes achieved or not achieved. For any outcomes that are not achieved, the evaluator should analyze the sequence of events and attempt to determine the cause using the questions **at right.** The questions **below** may further help determine root cause.*	✓ What happened? ✓ What was supposed to happen? ✓ If there is a difference, why? ✓ What is the impact of that difference? ✓ What should be learned from this? ✓ What corrective actions are recommended?

1. How did the lead PIO or public health operations officer activate a rumor control (public inquiry) center?
2. What staff supported the hotline?
   a. What training were they provided on how to handle calls?
   b. What types of questions were they asked by the public?
   c. What types of responses did they provide? Were these adequate?
3. What rumors were detected and corrected?
4. What rumors were not detected or not corrected?
5. What impact did the rumors have on response operations?